

PRINTED: 06/09/2016  
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN7701	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01  B. WING: _____		(X3) DATE SURVEY COMPLETED  06/06/2016
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, SEQUATCHIE			STREET ADDRESS, CITY, STATE, ZIP CODE 360 DELL TRAIL, PO BOX 878 DUNLAP, TN 37327		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the annual Licensure survey conducted on 6/6/16, no deficiencies were cited under 1200-08-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

4009

IEQ821

If continuation sheet 1 of 1